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# The Class of 1960



*Viri . . . feminaeque, MDCCCLX*

David Lawlor

On Friday, September 21st, the Class of 1960 was officially introduced to H.M.S. The incoming first year class registered and was addressed by Dean Berry, who cited the great strides made in the field of medicine in the first half of this century and welcomed the new students into what journalists have termed "The Golden Age of Medicine."

Who are the members of 1960, and what are they like? There are 115 first year students, chosen from a total of 1370 applications, and the class includes 11 service veterans and 6 women. They come from 27 states and 2 foreign countries (Canada and India). The largest group of students come from New York State (29) with the Massachusetts delegation second (22), followed by Ohio, New Jersey and California next in order with 11, 8 and 7 representatives respectively.

There are 47 undergraduate colleges represented in the entering class—31 students from Harvard, 9 each from Princeton and Yale, and 4 from Stanford. Amherst, U.C.L.A., Columbia, Cornell, M.I.T., Tufts and Williams each have 3 graduates in

the class. All but 3 of the entering students have completed 4 years of college or have earned their baccalaureate degrees. (100 of the 1370 applicants were college juniors.)

In the extra-curricular department we find that the Class of 1960 boasts 17 secondary school valedictorians and 33 National Honor Society members, as well as 21 high school yearbook, newspaper or magazine editors, 13 varsity team captains, 5 winners of Bausch and Lomb Science Awards and 4 Westinghouse Science Talent Search finalists.

College honors include at least 18 Phi Beta Kappa keys. Twenty-seven members of the incoming class were on varsity athletic teams or served as team managers, and 28 were either in college glee clubs, university bands, concert orchestras or chamber groups. There are 15 ex-presidents (of student government, fraternities, judicial boards and athletic associations) in the class. Other members were active on campus radio stations, debating, religious organizations and student counseling.

A glance at the enormous variety of summer jobs held by 1960 during their college years shows a wide

range of experience (and imagination). There were 27 camp counselors (including 5 waterfront directors), 20 lab technicians or assistants; 10 hospital orderlies or attendants; 3 lifeguards; 4 house painters; 3 shoe salesmen; 2 service station attendants; 2 sailing instructors; 2 dish washers; 2 baby sitters; 2 postmen; a landscape gardener; a plumber's helper; a clarinet teacher; a brewery laborer; a commercial fisherman; a bartender; a Good Humor man; a heavy construction laborer in the Texas oilfields; a printer using antique methods at Old Sturbridge Village; an author of a packaged radio show; a railroad fireman; a runner in the New York insurance district; a chinchilla-colony operator; a short-order cook; a musical instrument repairman; a milk man; a laundry truck driver; a stock clerk at a mail order dress manufacturing concern; and a caretaker of a tropical fish collection.

Twenty-two have begun their medical careers in the marriage fold. None of them have any children as yet.

Such is the character of H.M.S. 1960, and so begins another installment in the history of Harvard Medical School.



David Lawlor

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# "Religio Medici"

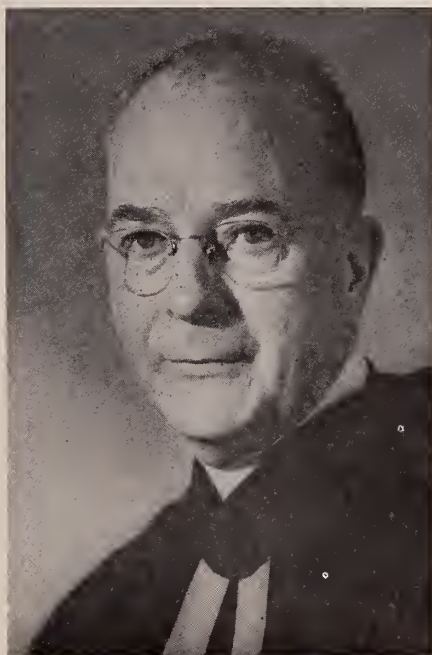
*The Reverend Douglas Horton*

PROFESSOR OF THEOLOGY AND DEAN OF THE FACULTY OF DIVINITY  
HARVARD UNIVERSITY

The title "Religio Medici" is properly used by Sir Thomas Browne for his often-read essay of the seventeenth century, because he himself was a *medicus* and had gained the right to say what a doctor's religion might be. It is not so with me. The title of any set of observations I might make on the relation of religion to medicine should more properly be *Medicina Religiosi* or something of the sort, for I speak as the Dean of a Divinity School about a profession whose discipline I have never undertaken, and which I know only by looking at it from the outside and through the friendships that a parson inevitably cultivates with the neighborhood physicians. I use Sir Thomas' title, however, since it is so much more familiar, and since I shall want to pilfer from him now and then a brief quotation.

I wish to stress *religio* in its modern, evangelical sense as a relation to God and not in the sense into which it often lapses as *morality*, the science of the relations of man to man.

There is, I take it, a good deal of discussion to be expected in certain places about the ethics of the medical profession. The doctors of Britain are said to be confronted by a whole new set of moral questions arising from the new relation of medicine to the State—due chiefly to the now established status of many physicians as officers of the government, as it were—but we should not need to go for our troubles so far afield. Questions as to the legitimacy of artificial in-



*Dean Horton*

semination, of abortion, of euthanasia, for instance, perplex many in our own country and will continue to do so. Obviously Christian moralists must take these matters into their purview and study them in the perspective of the best ethics of the past, but at the moment I turn away from problems of this sort, toweringly important as they are, to one which, I believe, is even more basic, related to the moral problem but not to be equated with it—the peculiarly religious problem.

Let me begin with the proposition that *medicine can be as cleanly, as purely, scientific when undertaken with Christian motives as when not.*

The Christian motive is simply stated: To love God and man. To be sure, when this motive becomes

tangled with moralities of various types, the latter being lifted into the realm of absolutes, my proposition does not hold. If, for instance, it becomes part of a man's religion to refuse to be vaccinated for smallpox or allow his children to be vaccinated, as was the case over so broad an area in New England a century ago, he cannot be said to be open to all the insights of science. At one point, at least, a motive which to him is religious has thrown an obstacle into the way of free scientific research. But this afternoon we are defining the Christian motive with theological care, as the love of God and man, protecting it in its absoluteness from any particularistic applications.

I do not know any reason, negatively speaking, why a doctor who believes that God is love cannot complete an appendectomy as skillfully as one who does not. I know of no specifically Christian method of curing the whooping cough, but there is no specifically anti-Christian or un-Christian method for doing so, either. Motivation and technique lie in different fields of discourse.

One sometimes hears it said that religion involves a commitment which may stand in the way of any kind of research. The Socratic dictum that the man who would be wise must follow the truth wherever it leads, is held to mean that that man can carry no presuppositions with him into his search. If, for instance, he believes in God, this very belief may color his findings. This may in a sense be true, but the believer is no more hobbled by pre-



suppositions than an unbeliever. Disbelief in God, or an uncertainty as to whether God exists or not, may also color one's findings. It is in fact impossible to think except on premises of some sort: One cannot sew with the thread of thought without tying some kind of knot at the end of the thread, as a Swiss theologian has observed. A commitment to God, or against Him, or to indifference concerning Him, may cast its shadow on the work one has in hand, but it is no blacker a shadow in the one case than in the others: It is always of the same quality—the shadow of presupposition.

A Christian as a medical man may formally enjoy the same hope of success in both his practice and research as one who is not a Christian.

But now let us pass from this area of balance and neutrality to a more affirmative proposition: *A physician with a faith in God is likely to establish a different relationship with his patient from the relationship effected by one who has no such faith.*

If you believe that human beings, for all their alleged intelligence, are really like the ants of the earth or the fish of the sea that are born, grow up, produce young, weaken and die in an unending and essentially meaningless stream, though custom may teach you an agreeable bedside manner improved by the prospect of good pay from the patient, you can hardly feel toward him exactly as you would if you believed him to have been brought into life by a God who had and has a real concern for him, counts upon him to fulfill His own particular purpose in existence, and intends that he shall not be lost in time or in eternity.

My friend, Dr. J. Edgar Park, who died recently, told me once of visiting a sickroom in his parish in which a young girl, the daughter of a family, lay ill, apparently in her last hour. The mother was kneeling beside the bed praying through her tears. The father was seated nearby

with his head in his hands. Dr. Park asked them to come with him into the next room for a moment, and there he said to them, "Do you not realize that you may be signing your daughter's death warrant: Why don't you pray to God about her?" "Pray!" said they, "What have we been doing?" Said Dr. Park, "By prayer I mean talking with a God Who is on the side of life, to One Who, because His character is that of love, will do the right thing by your daughter. I do not know whether your daughter will live or not, but this I do know, that whether she lives or dies, she will be in God's hands." They went back into the room, a new light in the father's eyes, a new lightness in the mother's step. Whether their new-won confidence communicated itself to the daughter at that time when she needed every support for her will to live, one cannot say. She did, however, live—and one can wisely guess that the new confidence did the daughter no harm.

Now some physicians come into a sickroom with a communicable confidence that an over-ruling Providence is present, too. This Providence is a loving God: He will not invade a human life or a human situation, because He is not a tyrant, but He is always on the side of life, temporal and eternal. Can it be thought that the influence of that doctor on the patient will be as ambiguous as that of one who sees no divine meaning in human life whatever?

Though faith is no substitute for skill, is it not a companion to skill? Does it not call to skill as a means by which a human compassion may be expressed which parallels that of the loving God Himself? Does it not help me to see my patient in a light which will attract me to my utmost skill? I shall surely treat him differently if I regard him as an immortal soul with an ailing body than if I see him only as a kind of living cadaver.

Sir Thomas Browne at least saw all things *sub specie aeternitatis*. No

patient was brought to him by chance; to him chance was ruled out of every situation by the presence of God: "Surely there are in every man's life certain rubs, doublings, and wrenches which pass a while under the effects of chance, but at the last, well examined, prove the mere hand of God." It would seem that a belief of this sort on the part of a physician would be likely to establish a more positive, a more personal, relation between him and his patient than would be expected if he had no such belief.

*In some cases of a psychosomatic nature, the believing doctor can be of direct religious help to a spiritually distraught patient.*

Dr. Schweitzer, of Lambarene, tells how, on one occasion, his own young native helper came into his office with an almost ashen face to tell him that he was soon to die. He had come in hungry from the field, taken from the corner of his hut a bowl which seemed clean and eaten his bananas in it. Before he had finished his meal, his brother came in, looked at the bowl, asked where he had found it, and then given his brother the terrifying news that he had eaten yams from it a little before without cleaning it afterwards. Now yams were the helper's taboo. He had known from infancy that if he tasted yams he would die. And the unfortunate end of the story is that he did die.

Some of you who have served in the Caribbean and Central America, and in other parts of the world where magic reigns, know that a curse laid by a person who is held to be a witch doctor sometimes works the same way: The person cursed expects to die and dies.

In these cases, ordinary medicine is apparently of no avail. Even the great Dr. Schweitzer could not save his helper. But if the attending physician is a medicine man in whom the patient puts confidence and who happens to know the proper religious formula for allaying taboos or neutralizing the venom of a curse, he can effect a cure.



We now know that the so-called civilized world is not nearly so far removed from the dark realms of the jungle as once our fathers thought. Fears still govern people: fears still produce disease: I presume they still induce death in some cases, even on Beacon Hill. We no longer suffer from taboos and curses, except those subtly laid by the society in which we find ourselves, but it is still medicine to the spirit, still the beginning of delivery from our fears, to be ministered to by a person who commands confidence and who knows enough of his patient's spiritual difficulties, through living in the same spiritual world, to be able to say the word to resolve them. A well-known Chicago di-agnostician once told me that he believed that sixty per cent of his cures were psychological. Obviously not all psychological difficulties are spiritual; but even the few cases of cure which you have effected in patients by simply witnessing to your own faith in God must serve to highlight the need for doctors whose own religious insights are such as to enlighten these minds and so bring health to the bodies of their patients.

Such a witness Sir Thomas could make: "I thanke God I have not those strait ligaments, or narrow obligations unto the world, as to dote on life, or be convulst and tremble at the name of death: Not that I am insensible of the dread and hor-our thereof, or by raking into the bowels of the deceased, or the continuall sight of Anatomies, Skeletons, or Cadaverous reliques, like Vespilloes, or Grave-makers, I am become stupid, or have forgot the apprehension of mortality, but that marshall-ing all the horrors, and contemplating the extremities thereof, I find not any thing therein able to daunt the courage of a man, much lesse a well resolved Christian."

I cannot but believe that Sir Thomas Browne, ready to make such a witness, would have brought at least an atmosphere of cure into the sickroom. He of course knew

## THE GEORGE W. GAY LECTURESHIP

Dr. George Washington Gay, of the Class of 1868, was one of the first clinical teachers at the Harvard Medical School. Born in Swanzey, New Hampshire in 1842, he entered the Medical School in 1864 after an apprenticeship under a New Hampshire physician, and in his fourth year he served as Surgical House Officer at the Boston City Hospital, receiving both his Harvard M.D. and his City Hospital diploma in 1868. At the turn of the century ill health compelled him to give up active practice, and he diverted his efforts to projects for promoting the welfare of both physicians and patients. In 1917, Dr. Gay gave a sum of money to Harvard for the establishment of a series of annual lectures "to the advanced, or graduating classes in the Medical School upon Medical Ethics, and upon wise and proper methods of conducting the business of physicians, as relates to fees, collections, investments, etc." The Gay Lectures have been given in the intervening years not only by prominent physicians, but also by distinguished leaders in other fields.

On May 16 of this year, the Gay Lecturer was the Reverend Douglas Horton, Dean of the Harvard Divinity School. Dean Horton, who was born in Brooklyn, New York,

received his A.B. from Princeton University in 1912. He received the degree of Bachelor of Divinity from Hartford Theological Seminary in Connecticut in 1915, having taken a year's graduate work abroad after leaving Princeton. In addition, Lawrence College, Chicago Theological Seminary, Princeton, Marietta College and Beloit College have conferred honorary degrees upon him.

A Navy chaplain during World War I, Dean Horton served churches in New England and Chicago until 1938, when he was appointed Minister of the General Council of Congregational Christian Churches, a position he held until coming to Harvard in July 1955. He is the author of several books, and in 1937 edited "The Basic Formula for Church Union." In addition, Dr. Horton is the United States Member of the Editorial Board of the *Congregational Quarterly* of London, a Member of the Central Committee of the World Council of Churches and Moderator of the International Congregational Council. He is also Chairman of the Board of the American University at Cairo, and a Trustee of Union Theological Seminary and of Princeton University.

nothing about psychiatry in his day, and I now am not speaking of psychiatric situations. I am suggesting only that medicine as medicine has certain psychological overtones which the spiritually competent will understand better than the spiritual-ly incompetent.

Entirely apart from spiritual aid consciously imparted in the way I have just suggested, *the unconscious view of life taken for granted by the Christian doctor affects his professional manner and purpose*, and the fact that our American doctors live within that realm called Christendom, where the principles of Christian faith and the standards of its ethics are discernible, albeit vaguely, is one of the main reasons why both the intellectual and the ethical levels of the profession are

as high as they are.

Surely we pay too little heed to the truth that science itself as we know it today has had its best chance where the Judeo-Christian, united now with the Greek, tradition has made itself felt. Why did it not develop under Hinduism? Confucianism? Perhaps an illustration from the Mohammedan world will provide an illustrative answer.

A number of years ago (as I may have told some of you already) I visited the American University at Cairo, Egypt. This is a missionary, but not a proselytizing, institution. It tries to transmit Christian ideas without injuring the values of Islam. The President, opening a door in a corridor, remarked that this was the evangelistic room. I went in, expecting to find myself in a chapel.



Not at all: it was a chemical laboratory. When I turned to the President for explanation, he said, "The boys come to us believing that the world is hung from the belt of a god who rules wholly by whim. One cannot make any prophecies about it. Though it may be a little more than a hundred miles between Cairo and Alexandria today, it may be a little less tomorrow. According to some schools, even that which is morally good today may be morally bad tomorrow, and vice versa. The will of Allah is absolutely unknowable. When they come in here they learn that over a hundred years ago it was discovered that if you put an atom of hydrogen with two atoms of oxygen, you will have a water molecule. They make the experiment which proves this on Monday, repeat it on Tuesday, and Wednesday . . . It finally comes over them that this is a universe of law—and it is only one step from that to the idea that it is a universe presided over by a God of character, of a character which can be depended upon."

I hasten to point out that not all of Islam has the conception of God I have been describing. There seems to be in Islam, however, a less firm belief in the unchangeable and dependable character of God than there was in the areas of Christian Europe where modern science did actually take its rise. The lead given by Avicenna could not be maintained. I am ready to take my stand with Professor Whitehead that the intellectual foundation on which medical and all other contemporary sciences rest is our faith, often implicit and undescribed, in a God of character. Long before science celebrated its contemporary victories, our Sir Thomas was writing, "I call the effects of nature the works of God, whose hand and instrument she only is."

More than this, the amazing standards of public service and personal integrity which each doctor in the western world believes it his duty to maintain are an ac-

companiment of the gospel.

To indicate the difference in level between the standards of medicine and those of some forms of business (which themselves are rising today), let me remind you that Banting and Best had to protect their discovery, in order to save it from monopolization by unscrupulous manufacturing chemists, through the device of the patent. Once patented, however, they made it available to the profession in accordance with a time-honored tradition.

Note what occurs where medical tradition has no support from religion. I quote from Dr. Chesterman:

"An oriental doctor assured the writer that in his country there was no such thing as medical ethics. Another, whose job was to run a government tuberculosis dispensary, revealed the fact that his professional colleagues would not co-operate because a case of tuberculosis in a well-to-do family was for them a gold-mine—so many visits, so many bottles of medicine, so many injections, so many X-rays before the signing of the death certificate."

I, myself, have witnessed the vilest prostitution of the ethics of the profession in the direction of commercialization in some of the Indies, East and West, where the faith had deteriorated.

Without necessarily thinking the matter out, the Christian doctor knows that he cannot rise to the height of his calling save as he enters into the conception that he is an instrument in the hands of a loving God. This offers him his chance to live in real freedom (since God does not make a puppet of him), in responsible freedom (since he feels his debt to God), his own love for mankind arising in response to God's love.

Even when he is far from the Church, the Christian doctor carries with him the relationships of the Church. He is compassed about by a cloud of saintly witnesses, so that he might say with Sir Thomas:

"I have practiced that honest artifice of Seneca, and in my retired and

solitary imaginations, to detain me from the foulness of vice, have fancied to myself the presence of my deare and worthiest friends, before whom I should lose my head, rather than be vitious."

It is belief about the nature of God, diffused but real, that has helped western man to establish the possibility of scientific procedure and of moral decency in the medical profession.

If all these things are so, I believe that we of the Medical and Divinity Schools of the University, might see more of each other to our mutual advantage. I shall be greatly surprised if an inter-disciplinary course (it might be called The Theology of Medicine) is not called for one of these days.

As a matter of fact, in the Divinity School we are hoping next year or the year after to set up courses in religion and *mental* health. These would be presided over by a theologian having a knowledge of depth psychology and a psychiatrist with religious intuitions. Perhaps eventually a similar happy combination could be effected in the realm of religion and straight medicine.

The students in both schools are undoubtedly in need of the broadest contacts they can find. A doctor, like a minister, should be educated in an environment of genuine university quality. Isolation and over-specialization are social diseases which a university should be able to overcome.

But all this is the subject for another discourse and much further discussion. At the moment I am interested only in establishing the fact that a doctor with a religious experience may not only be as well equipped technically for his task as one who is completely secularized, but that he has certain attributes, of which he may or may not be conscious, which make him a better doctor. There is something to be said for the attitude of the author of *Religio Medici*: "I cannot goe to cure the body of my Patient, but I forget my profession, and call unto God for his soule."



# The Ways of Life and Heart Disease

## A Plea for Positive Health

Paul D. White, '11



Dr. White

I appreciate and welcome this opportunity to speak to you on a subject which has to my mind become one of the most vital issues in the private as well as the public health of our country today. Throughout the land there has been developed by private enterprise and public support an excellent program of medical research and training in the study and treatment of the host of diseases that beset us. Beginning with the infections, one after another of these diseases has surrendered to our efforts, or is being attacked in a very promising way. We may hope that, as William Osler prophesied in January 1901, preventive medicine in this respect will have yielded great results during the present century. But we

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Editor's note: This address, given at the Alumni Day Symposium, May 31, 1956, was also given in large part at the meeting of the Syracuse University Medical Alumni in Syracuse, New York, June 9, 1956, and at the commencement exercises of the Bowman-Gray School of Medicine of Wake Forest College at Winston-Salem, North Carolina, June 10, 1956. Dr. White also gave it at the annual meeting of the Maine Medical Association in Rockland, June 25, 1956. In addition, it will be published in the November issue of the Maine Medical Association Journal.

need, for several reasons, something more than that.

From my own experience in practice and in public health during the last 40 years, I believe that we should heed the advice of our medical ancestors who apparently knew more, or at least preached and practiced more than we, a program of positive health habits. The habit of adequate exercise, for example, is just as important, I believe, as one's sleep, one's work, and one's food. We know a thousand times more about diseases than our predecessors did generations ago, but apparently infinitely less about health, at least we seem to, although I dare say that it is really only a matter of our faulty practice. We could certainly take a page or two of profit from an old volume entitled *The Regimen of Health*, translated into English in 1541 at the request of the then victorious King of England and of France, Henry VIII, from the teachings passed down through the preceding centuries from the world's first medical school at Salerno.

Now I do not mean to say that we should become fanatic on the subject. We must use common sense and try to strike a balance between oversolicitude about our health, decried over two millennia ago by the Greek philosophers, and our almost total neglect today, as indicated by the general disregard even for their own health by the medical profession in this country at present. Let me quote for a minute on both scores from the Dialogues of Plato, written about 400 years before Christ:

"Well, I said, and to require the help of medicine, not when a wound has to be cured, or on occasion of an epidemic, but just because by

indolence and a habit of life such as we have been describing, men fill themselves with waters and winds, as if their bodies were a marsh, compelling the ingenious sons of Asklepios to find more names for diseases, such as flatulence and cattarrh; is not this too, a disgrace?

"Yes, he said, they do certainly give very strange and newfangled names to diseases." (And that still goes on, I might add.)

"Yes, I said, and I do not believe there were any such diseases in the days of Asklepios . . .

"Bear in mind that in former days, as is commonly said, before the time of Herodicus, the guild of Asklepios did not practice our present system of medicine, which may be said to educate diseases. But Herodicus, being a trainer, and himself of a sickly constitution, by a combination of training and doctoring found out a way of torturing first and chiefly himself, and secondly the rest of the world.

"How was that? he said.

"By the invention of lingering death; for he had a mortal disease which he perpetually tended, and as recovery was out of the question, he passed his entire life as a valetudinarian; he could do nothing but attend upon himself, and he was in constant torment whenever he departed in anything from his usual regimen, and so dying hard, by the help of science he struggled on to old age.

"A rare reward of his skill . . .

"Asklepios did not instruct his descendants in valetudinarian arts because in well-ordered states individuals with occupations had no time to be ill. If a carpenter falls sick, he asks the doctor for a rough and ready cure—an emetic, or a purge, or a cautery, or the knife—these are his remedies. Should any

prescribe for him a course of dietetics and tell him to swathe and swaddle his head, and all that sort of thing, he says, he sees no good in a life spent in nursing his disease to the neglect of his customary employment; and therefore bidding good-bye to this sort of physician, he resumes his ordinary habits, and either gets well and lives and does his business, or if his constitution fails, he dies and has no more trouble."

In commenting upon this in 1939, I wrote what of course comes to mind today, namely that there must be a sensible middle course, taking advantage first, naturally, of all the routine public health measures that have been introduced to protect us, and secondly, otherwise establishing habits of positive health, free of valetudinarianism, that can add at least to our comfort and very well may materially reduce some of the common threats of today, such as hypertension, coronary thrombosis, and the psychoneuroses, although much research still remains to be done in detail concerning their efficacy. Let me quote from that paper of mine published in 1939:

"That old Asklepiian practice (of carrying on one's occupation despite some illness which in those distant days was incurable) certainly represents one extreme of medical care, or perhaps better called lack of care, but I rather suspect, in fact I am quite sure, that the 'new medicine' that Plato ridicules and which is current in our own day represents the opposite extreme, probably equally pernicious. We have become soft and careless in acquiring many of the ills of mankind, except for infections upon which we have concentrated largely to the exclusion of other disease prevention, but once we have acquired these ills we are prone to yield to them and to live lives of apprehension and invalidism. There must be a happy mean.

"It is almost certain that our forebears practiced far better than we various rules of health that tend to delay or to prevent the so-called de-

generative diseases of middle age, though vast numbers did succumb at early ages to the infections which we can now prevent."

Now let me briefly comment on some of these environmental factors and ways of life which may influence our health. I shall not discuss basic and constitutional factors, which are certainly in many instances of great importance, but about which we can ourselves do little or nothing, such as race and heredity and age and sex. If we believe in a fatalistic way that nothing can be done to counteract unfavorable influences of these factors, life for us all would be grim indeed, but I for one feel quite certain that the establishment of common sense positive health measures can to a surprisingly large degree not only neutralize, but actually transcend the hazards that may be inherent in such basic factors. What are some of these environmental factors that may act favorably or unfavorably upon us?

A. *Work.* The first that often comes to mind at this time in mid-century, but which actually has been a source of worry to mankind in every generation since the beginning of recorded history, is "stress and strain." We should carefully distinguish, in the first place, between the stresses of physical, of mental and of emotional nature. In every case we must consider the host as well as the stress, for there are all degrees of resistance and of sensitivity of the host, as well as degrees of the stress itself, which makes an analysis of this environmental factor a very complicated problem. Physical strain includes, of course, much of the life work of many millions of persons in the world today, but it has yet to be proved that, barring rare exceptions of extremely strenuous labor and accidents on the job, work per se ever physically hurt a healthy man, woman, or child. Unhappily, industry and other physical occupations have been blamed (for lack of a suitable substitute for such blame in our way of life today) as the cause of many of the ills, even

including coronary atherosclerosis, which in all probability are in no way associated with such physical activity. This is a serious error still currently practiced today, and for the sake of the future of this country urgently demands correction. Not only is physical work not responsible for most of these ills, but it is probably one of the most potent health habits which we should make full use of, perhaps most of all at older ages, when too many hundreds of thousands of persons are retired to sit in armchairs and to drowse in front of television screens day after day, and even year after year, both to the detriment of their own health and to that of society, which could with more wise planning utilize their experience and their accumulated wisdom, often for a good many years more though perhaps at a decreasing tempo. I dare say that the one most important measure to improve and to maintain the health and happiness of our older citizens is to keep them working both mentally and physically; this would make unnecessary at least half of all the measures, medicinal, social, economic and educational that are now laboriously being introduced as geriatric devices. Of all my comments today this perhaps is of the greatest importance.

What I have said about physical work applies, I believe, also to mental work, with one qualification, and that is that some sort of physical exercise should be helpful to the intensive mental worker, both for the sake of relaxation and for the benefit to the whole body of such exercise, which I shall come back to shortly. As in the case of physical stress and strain I don't believe that mental stress and strain hurts a healthy man, woman, or child, provided it is not extraordinarily severe or prolonged, and provided occasional respites for relaxation are offered, preferably both by physical exercise of almost any sort and by some interesting avocation. This has been our program for the President. It is the neglect of useful measures of that type,



and overindulgence in other practices that are doubtless the cause of the nervous prostrations, the high blood pressures and the coronary thromboses that are currently blamed upon the stress and strain of the job, no matter what it is, with possible rare exceptions.

Thus, it is my experience, and hence my belief, that hard work, physical or mental, never killed a healthy man. Nor emotional stress either with the rarest of possible exceptions. Practically all the cases that I have heard about, who have died under emotional stress (except in the case of suicides) have adequate underlying physical causes with irritability of heart or brain induced as a final event. Let me go back again in history on this point. Three times since the birth of Christ, that I know about, the city of Rome has been visited by epidemics of sudden death; I dare say there have been other occasions too of which I know nothing. During the first half of the first century A. D., many prominent Romans, political, social and professional leaders, died suddenly and apparently unexpectedly while going about their daily life, as recounted by Pliny, the Elder. Undoubtedly from the description most of these deaths were due to coronary insufficiency, but there were no autopsies. Remember this was at the height of the prosperity of the Roman Empire, and doubtless the senators, the lawyers, and even the doctors had their own chariots and ate more than was good for them.

In the winter of 1705 to 1706 another epidemic of sudden deaths occurred in Rome to the consternation of the populace, who feared God's displeasure and supernatural causes. However, the combined wisdom of Pope Clement the Eleventh and his physician, Lancisi, resulted in the institution of autopsy study of similar cases during the next winter. Every case so studied demonstrated a natural cause of death, circulatory as a rule, for example a cerebral hemorrhage or a ruptured aorta. A book resulted from this

study dedicated to the Pope and called by Lancisi *De Subitaneis Mortibus*. Bishop John Wright and I are having this book translated, and we hope some day to publish the translation with an appropriate foreword.

And now we come to this last winter. A few weeks ago, when I was in Rome, I was asked to see patients who were fearful of another epidemic of sudden deaths there during the winter. The first case, a public official, although not yet a patient, was justifiably worried, for he was a perfect candidate for coronary thrombosis, and his electrocardiogram was already abnormal. Advice in time may rescue him if any advice we have today can be helpful. At the time of my visit to Italy early in May an interesting, beautifully-equipped and well-staffed hospital was inaugurated on a remote hillside in southeastern Italy next door to a monastery, which is visited yearly by many thousands of pilgrims from all over the world, who come for help, physical and spiritual, to Padre Pio, a Capuchin monk devoted to the welfare of these pilgrims. Here is an opportunity for the study, as the Pope himself announced, of psychosomatic medicine. Without a doubt, as recognized by our forefathers, the psyche has a very important influence on the soma, just as I am sure the soma has on the psyche, but we are barely at the threshold of knowing how and why. In some way, I believe, the bad effects of the alarm reaction, of grief, of fear, of anger, and of pessimism can be neutralized and even superseded by inculcation of the positive virtues of courage, patience and optimism. Although many individuals are born with these traits, others must acquire them, and we doctors can help. And so we come to the second important positive aid to health, namely

B. *Equanimity*. Let me quote briefly from William Osler's valedictory address, entitled "Aequanimitas," presented at the University of Pennsylvania on the first of May, 1889.

"... a calm equanimity is the desirable attitude. How difficult to attain, yet how necessary, in success as in failure! ... One of the first essentials in securing a good-natured equanimity is not to expect too much of the people amongst whom you dwell ...

"Hence the need of an infinite patience and of an ever-tender charity toward these fellow-creatures; have they not to exercise the same toward us?

"... A distressing feature ... which will press hardly upon the finer spirits among you and ruffle their equanimity, is the uncertainty which pertains not alone to our science and art, but to the very hopes and fears which make us men. In seeking absolute truth we aim at the unattainable, and must be content with finding broken portions ...

"It has been said that 'in patience ye shall win your souls,' and what is this patience but an equanimity which enables you to rise superior to the trials of life? Sowing as you shall do beside all waters, I can but wish that you may reap the promised blessing of quietness and of assurance forever, until

Within this life,  
Though lifted o'er its strife,

you may, in the growing winters, glean a little of that wisdom which is pure, peaceable, gentle, full of mercy and good fruits, without partiality and without hypocrisy."

C. *Exercise*. Now let me introduce briefly the more mundane factors of exercise and diet. To make the most of our lives in their usefulness, happiness and longevity, it behooves us to try to ascertain the value of certain ways of life for ourselves, our friends, our patients, and the world at large. Much has been said pro and con physical exercise, and we must still await more evidence of its value in the prophylaxis of such bothersome ills today as hypertension, coronary thrombosis and nervous prostration. Studies now going on are beginning to indicate a positive value, and many



of us hope that some good is being done in the way of preventive medicine in these directions by the establishment of sensible exercise habits, as well as in the favorable effect on the circulation as a whole and in improving digestion and counteracting the results of excessive nervous tension and strains. Good muscle tone in legs and arms and diaphragm without question aids the circulation, and we can feel, as I have many times personally, the delightful relaxation that comes with muscular fatigue. Some claim that they can live long and healthy lives with very little or no exercise, but I believe there is a difference between positive health and simply the absence of disease. So strongly am I convinced that exercise in proper amounts that I am making every effort to get the American young and middle-aged male back on his feet again. The women don't need exercise so much, though they can profit by it too. By the time I present these remarks I shall have visited Chicago to take part on Saturday morning, June 2nd, in the inauguration of several *safe bicycle paths* there, prior to the building of a proper path from a suburb into the city which will enable thousands of persons, men and women of all ages, to cycle to and from work regularly and safely. A ride of five or six miles twice a day (that is too far to walk) will be good for their health and their pocketbook and for the traffic congestion in the city. There is no reason whatsoever why this can't be done in nearly every city in the country where eventually several paths in each can be built. Of course, this requires initiative, planning and money, but in the long run it will be more than worth while to establish this routine and practical health measure to counteract, to some degree at least, the soft, push button way of life that we are threatening to bequeath to our children, who will need more than gadgets to survive in this world tomorrow.

Incidentally, it is of considerable interest that not only work (phys-

ical and mental) is being utilized in the convalescence and rehabilitation of cardiac patients, but even exercise in sports as a therapeutic measure as noted by Rautmann in 1954.

Although we cannot prove as yet that John Dryden was correct when he wrote about 1680 to a kinsman, who lived in the country, a letter in which the following stanza appears, there is, I believe, more truth than poetry involved. I quote:

"By chase our long-liv'd fathers  
earn'd their food;  
Toil strung the nerves and purified  
the blood  
But we, their sons, a pamper'd race  
of men,  
Are dwindled down to three score  
years and ten.  
Better to hunt in fields for health  
unbought  
Than fee the doctor for a nauseous  
draught.  
The wise for cure on exercise de-  
pend;  
God never made his work for man  
to mend."

D. And now, finally, I would add a word about *diet* and *obesity*. Tobacco and alcohol I shall dismiss with the simple statement that their excessive use can be very harmful, and that in the face of certain diseases and disorders they can do damage; but their moderate use in healthy persons seems to do no harm. So far as obesity is concerned, we all know that life insurance and other mortality statistics do definitely point to the decreased longevity and more common illnesses in persons with considerable overweight, but the details of the diet, not the calories per se, are now being more extensively studied in researches on man himself. The first findings have indicated in several parts of the world in countries where different races or different groups of the same race ingest quite different amounts of fat in their diets, that those who are lowest in the economic scale eat the least fat, have the lowest content of cholesterol in

their blood serum, and suffer the least from coronary thrombosis. My own newest adventure in cardiovascular epidemiological research earlier this spring was as a clinical colleague of Ancel Keys and Bronte Stewart in comparing the Hawaiian Japanese (with origin in southern Japan) with the Japanese still living in southern Japan. Although my own data have not been completely analyzed as yet, and although I have not yet learned what my physiological colleagues found in the comparison of the serum cholesterol contents, it was very clear that the two chief differences in the two groups were that the Hawaiian Japanese ate much more fat and had more coronary thrombosis and at a much younger age, typical of our American pattern. Thus, is our prosperity endangering our lives, as perhaps did that of the well-to-do Romans in the first century A. D.? It may well be so, but much more study still remains to be done. Even if it proves to be true, we can still be prosperous though with some revision of our routine ways of life. We may actually enjoy the resumption of vigorous physical exercise, the cultivation of equanimity, and the substitution of an attractive diet such as that to which we became accustomed in southern Italy, at 20 to 25 per cent fat, for the excessively rich and quite unnecessarily fat-loaded diet of 40 to 50 per cent fat, to which we have become increasingly habituated in this country today.

In closing, I would make two pleas: first, for the more adequate support of epidemiological research on man himself to determine more accurately the beneficial or harmful effects of the various ways of life, and second, to urge you, my medical friends and through you, others, in this country or abroad, to support sensible habits aimed to achieve a state of positive health even before we have all the proof—we may all be dead before the researches are finished. Good health and a long life to you all!



# The Smoke Filled Room

Rolf Lium, '33

Editor's note: Rolf Lium, H.M.S. '33, is engaged in the practice of general surgery in Portsmouth, N. H. His article describing a meeting of the editorial board of the *Bulletin* was sent to several members of the board who attended the meeting described for comment. One of these members, practicing internal medicine somewhat west of Boston, commented in some detail. We felt that his remarks were engaging companions to Dr. Lium's article and they are appended in part as footnotes.

When the *Harvard Medical Alumni Bulletin* used to come across my desk, I placed it on a pile to the left. This was the group of statements, sheets, magazines and whatnot destined to be taken home for reading at some future time. On an evening, when I was in the mood, I would pick up the *Bulletin* and run through it, reading some things from beginning to end. When the classes appeared, there was a rapid movement to the items under 1933, wondering in passing who would ever care about the old-timers of '07 or earlier, and speculating how the neophytes of '48 and that general era could be so proud of raising families. My kids were now well along and rather taken for granted. Never did it occur to me that there was a plan behind the *Bulletin*; rather there appeared from nowhere the tacit assumption that the *Bulletin* is, therefore I have it.

A few months ago, someone had a brainstorm at the Harvard Medical Alumni Office. I suppose that it went something like this, "We need new members on the editorial staff of the *Bulletin*. What we have missed these past years is the unusual face. All of us are professors or striving-to-be professors, and we see each other in this committee and that; and we meet in the corridors of the Medical School or our hospitals. Let's go slumming to the areas where none of us really knows what is going on. Why not bring in from the hinterland some person who can tell us

about that wild, savage country where doctors compete for a living." \*

One can easily imagine that the editorial staff, once embarked on this policy, must have put down certain requirements, "well, he can't come from Philadelphia, or Chicago or Portland, Oregon. Why not place all of the H. M. S. graduates who live within a radius of 100 miles of Boston in a hat—no, only their names, please—and then pick one?"

It was thus that I became a member of the editorial staff, and now the *Bulletin* developed into a living, moving thing that came to fill my waking hours at night. Mine is an unfortunate habit of awaking at 2 to 3 A.M. Please help me, if you can. A large sum will be paid to anyone who will furnish a formula for sleeping through without interruption from 11 to 7. It should be stated in all fairness, that we are here dealing with a long line of mid-sleep wakers.

To return to the subject of this discourse, which is the *Harvard Medical Alumni Bulletin*; I began to think of this as my own little project and

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\* You may have noticed it from your side of the supposedly ivory tower, namely that there is a real paranoia on the part of the practitioners toward the full-time or even part-time academic men. Obviously, there isn't the slightest reason in the world why Dr. Lium should have this feeling, but most obviously from his manuscript he has it. To tell you the truth, as a very minor part-time man I have it. I think all of us who are not full-time in the hospital have slightly a feeling that we are being patronized, yet there is no obvious reason for this feeling. I think what we are driving at in trying to get a man outside of the Medical School area to be on the Editorial Board was an attempt to assuage this emotion. As you can see, what you have done is pick out a very superior practitioner and demonstrated that even in that league the paranoia exists. The very fact that he is on the Editorial Board and writes a literary masterpiece would serve to convince any other practitioner that we have loaded the Board with a ringer and further aggravate the state of paranoia.

conjured in my mind articles from all manner of alumni. In those wee hours one has the wildest imaginations. I thought of writing Dean Berry and asking him to submit an article on, "What's Wrong with H.M.S." There seemed a good possibility in Alan Gregg concerning, "Oil in Medicine Today." Unfortunately, the deadly sober scrutiny of the morning crosses out such extravagant ideas with the heavy pencil of the discriminating censor, and me says to I, "How is it possible that between us we could ever cook up such foolishness?"

There was a meeting called at the Harvard Club in Boston for the editorial staff of the *Harvard Medical Alumni Bulletin* for 5 P.M., Wednesday, March 7, 1956. During the day I wondered if it would not be proper to call John Merrill and tell him that things being as hectic as they were in these parts, it would be best to hold the meeting without yours truly. There was the usual run of work, and then there was the weather. I hesitate to make many remarks about the weather for fear someone in the audience will suspect me of running out of steam, but such is not the case.

Weather means a lot to anyone living in New England. We live around weather, and this is because we often have in the course of a single week enough weather to be registered as climate in other parts. Only a short time ago a physician called me to operate on a case of strangulated hernia in a hospital just nine miles from my home. He called at 2 P.M. Because of a rather severe snowstorm, I arrived at the hospital at 9 P.M. But the physician and patient appeared at 5 A.M., having negotiated five miles during this long interval. If anyone doubts the influence of weather on us New Englanders he has only to refer to those unscrupulously destructive dames Hazel and Carol.

On March 7th, the radio proclaim-



ed that it was raining in Boston, but snow was falling here. After running through a 20-mile band of sheer ice, where sleet, snow and rain were each striving for the upper hand, I arrived on Commonwealth Avenue. The Harvard Club is a noble institution, but it is a victim of the age when there is too much democracy. Our founding fathers promised everyone an equal opportunity, but they didn't give everyone the go-ahead to buy a car on the installment plan and run it into the city and park wherever one may. This is what one resents most about the Harvard Club of Boston. It is a small matter, but aren't you really bothered more by minor matters than by the great, magnificent challenges? The sum and substance of this argument is that one had best leave his car parked in the space behind the Harvard Club.\*

Having parked my car, I climbed the rear iron stairs of the Harvard

Club, stairs that sound a note of authority each step that one negotiates. There is a great door through which one cannot see. You really don't know if there is a cocktail party in full swing or an absolute blank when the door is pulled. Tonight it was dark, and only the light from the outer rooms crept in to fill the spaces like a soft murmur. This is the dining room of the Club, and on its walls hang the oil portraits of Eliot, of Lowell, of Conant and others. In this great, paneled room, one smells and feels antiquity. One is happy to enter an institution that is solid and respectable.

The editorial staff met in the Lincoln Room, which contains a large table around which are collected 14 chairs in red leather upholstery. The red is of a bright color, like the jackets of the British soldiers who fought the Revolution—nothing of the subdued red or maroon that graces the Harvard flag. Everyone

can drive 60 miles an hour and find a place to park at the end of this run. He senses this on our part, you see, so he tells us about the one time when it took him several hours in a snowstorm to drive a short distance. We should not be fooled by this sponge thrown to us.

seemed to be there at once, and the attendant brought in rye, scotch, bourbon, ice, ginger ale, soda and a big silver bowl of Harvard Club cheese nix. If our fires seem to burn low, it is not from a lack of proper stoking.

The agenda took over, "We have been thinking about succession for the editorial staff of the *Bulletin*. Some of the members never appear; others do not contribute." At this point the Dean spoke up, "We must remember that this is not an honorary society. We are all working members. If one cannot contribute, he does not deserve to belong." We began to search our souls for examples of individual weakness and lapses, when John Merrill, the Editor, spoke up, "Of course, we are not thinking of anyone present." Then smiles lit up, and for the moment we stagnated in friendly feeling. Should we serve for one year, two years or three? One year scarcely gives a person the feel of the problem. Three years is too long a period for a person to prove his incompetence. Two is the ideal compromise. It marks the point between greenness and over-ripidity. From now on, we will serve a couple of years each and then be reapointed or sacked.

Dr. Brooks was introduced as the new Editor. He is a tall fellow with glasses; quite an easy chap to meet. One gets the impression of a relaxed Ivy Leaguer who cornered four letters while breezing into one of the *laudes, cum, magna* or *summa*.\*

The *Bulletin* is a \$12,000 liability, and this hurts a New England conscience. Everything must pay for itself—in the idiom of commerce, one calls it being solvent. The natural touch for contributions are the pharmaceutical houses—those illustrious dispensers of relaxors, tensors, neutralizers and antagonizers. But they have stockholders to soothe, and there are advertising managers who stand guardian over the profits. We had been briefed on this problem a

\* He also is an expert ballet dancer, rifle shot and writes successful detective stories under an assumed name.





quarterly (three months) earlier. Each of us was to write to a company or group of houses to see what we could arouse in the way of advertising enthusiasm. After much soul-searching, we decided that only a professional advertising man could smash the atomic heart of an advertising agent. Suggestions from the audience out there are most welcome in this matter.

We went on to a consideration of Jane Mollman's successor. Jane has done a bang-up job for the Alumni Association these years. John Merrill has called the signals, but he has been too busy transplanting kidneys in identical twins to be concerned with the minutiae of the *Bulletin*. In order to know what sort of person Jane has been, one need only record the discussion of qualifications for her replacement. She must be able to do a lot more than type and take shorthand. She will have to know much about editing and preferably something concerning medicine. There will be the problem of handling the Alumni diplomatically, particularly the fellow whom you are hitting for a large gift, and whose son has just been rejected by the school. And after we had talked in this vein, someone made the suggestion that it all come packaged in a Powers model. It reminds me of the statement made by one of our illustrious professors during a lecture on pathology, "The ideal doctor's wife is half bitch, half saint, and rich as hell."

There was a survey, and it was loaded. One question asked, "Do you read the *Bulletin* cover to cover, or not at all?" Many got so mad about this all or none query that they wrote unkind bits which reflected seriously on the intelligence of the editors. The survey was a great success, for over 30 per cent of you answered, and what was told will help to tailor the *Bulletin* more to your tastes. The Harvard Medical Alumni want their facts dressed up to please. They want reporting as sophisticated entertainment. Through all of the replies, there ran the leitmotif of more about the School, about the



men who are Harvard Medical, what they are doing, who are their assistants, what are the new policies.

The reading tastes of our audience seem geared to the *New Yorker*. Someone with a flair has to go through the Alma Mater and write profiles on "Physiology," "Inside Gyn," or "The Coming-Out Party at Lying-In." We will try. One member of the editorial staff is to be made a committee to accept notes from Alumni, students and Faculty and incorporate all into a sort of "Talk of the Town."

John Merrill said, "We need an editorial for the next *Bulletin*."

Dean Berry had an idea. He has lots of ideas. As an outsider, who maintains no close connection with the School, I would like to pause for a moment and say a word about our Dean. Imagine if you will, a red-hot corporation lawyer who deals in millions; the manager of an opera company whose task is to reconcile prima donnas; the dedicated scientist who seeks only the truth, and all fakers be hanged—there you have the Dean.

"I would like to see an editorial written on medical teaching. There

is afoot in the country a movement to shackle the full-time teacher and not allow him to have any private patients."

Someone interrupted, "Come again, please. Did I hear you right?"

"There are states where doctors are trying to pass laws making it impossible for full-time teachers to see private patients. The argument runs something like this, 'These men have their staffs and offices paid for. Why should they compete with us who have to pay our own office rent?'"

Tom Lanman agreed to write the editorial. Jane Mollman hastened to state that it would have to be in soon. John Merrill said, "In about 10 days." Jane added, "No, it has to be in a week." Tom nodded, and then he stopped, "Oh dear, I am going to be away for two weeks, leaving on the 10th." Jane counted on her fingers and replied, "That gives you exactly three days." Dean Berry threw in, "I'll give you all of my data." And Tom said, "I guess that we can get it done by the 10th, before I leave."

Meeting adjourned. This is how *Bulletins* are made.

# Reflections on Medical Education

*Alfred Hurwitz, M.D.*

PROFESSOR OF SURGERY, STATE UNIVERSITY OF NEW YORK

AT NEW YORK CITY

It has been stated by some of the older members of the medical profession that the present generation of medical students lacks the degree of academic curiosity and the impelling desire to learn which were exemplified by the student of the past. The feeling has been expressed that the present-day student is not properly motivated and that he has sacrificed lofty ideals for material considerations. Statements of this type imply that either the selection of the student is faulty, or that those of us who are engaged in teaching have been remiss in the performance of our duties. There is no doubt in my mind that both explanations are relevant. The first criticism can be mitigated by a more judicious selection of students. This task is assuming greater proportions because of the diminishing number of desirable applicants for medical careers. The second criticism, however, is worthy of our most painstaking consideration. Are we doing everything in our power to ensure the proper maturation of the medical student? My reflections on this matter can be divided into two major categories. One concerns itself with the present lack of emphasis

on the altruistic and idealistic aspects of medicine, factors that constitute the art of medicine. Much more time should be devoted to describing the inner gratifications of medicine, the virtues of being intellectually and economically honest and the reasons for considering the practice of medicine a profession rather than a trade. I should urge the students to read "The Basis of Medical Practice," by Sperry, and Osler's "The Way of Life." Time spent on worthwhile reflections by the medical student will pay larger dividends to society than the accumulation of a few additional medical facts.

I believe that it is unwise and inappropriate to consider the medical student a person imbued with such great intelligence and experience that he can steer his own course without help. It is at this stage that proper advice and wise counsel will be most appreciated. Omission of important aspects of medical training is often a glaring defect in our present teaching program. There should be a coordinated plan of education that is enthusiastically embraced by the heads of the major clinical departments. They must see

the wisdom of an integrated program and must avoid selfish insistence on the importance of their own specialty. The medical student should be encouraged to view the field with a wide-angle lens rather than with "gun barrel" vision. In my experience, the latter situation will become manifest too frequently and too soon.

What should the medical student be taught? It would be presumptuous of me to assume that I knew the answer to that weighty question. It does seem, however, that it is a sad travesty on our educational system if we fail to imbue the medical student with a proper basic approach. It is only after the placing of sturdy cornerstones that the superstructure will be rendered safe. In this regard, Lippard deprecated the exploitation of medical students when he stated: "The question I would raise is whether this practice (excessive laboratory work) is educationally productive or is demanded for the convenience and economical operation of the hospital. The high school graduate in a school for medical technologists masters these simple techniques in a few weeks. It is hard to believe that it takes a medical stu-



dent two years. Could not the time spent on these chores be more advantageously devoted to the more basic aspects of medicine? Such methods of instruction seem quite appropriate for the automobile mechanic but do they belong in a university?"<sup>1</sup>

In this connection I should like to emphasize the importance of the return of a bed-side rather than a bed-front manner. I wince when I learn that in some hospitals "chart" rounds are being performed routinely. The patient then becomes a remote abstraction instead of the cynosure of all eyes. We must stress the fact that the student must be trained to take a complete history and to perform a careful physical examination. Furthermore, he must be encouraged to revisit the patient frequently, so that he can ply him with additional questions and re-examine him in the light of newer knowledge thus obtained. Unless the medical student is trained to employ his five senses and to think logically, his career will be as capricious as a cork bobbing in rough seas. This approach should entail encouraging the student to develop a proper perspective concerning the significance of laboratory data. The point may be emphasized that the laboratory is rarely helpful except in a confirmatory way if the physician has taken a complete history, has done a meticulous examination and has tied his findings together in a coherent manner. This basic approach to the patient should be emphasized by every clinician with

whom the student comes in contact. The chairman of each department should recognize the teaching capabilities of his staff and employ their services accordingly. It doesn't make sense to inflict upon the students a man who is not interested or qualified to teach. The responsibility of teaching should be imposed only upon those who possess the attributes that stamp them as teachers. Sometimes the chairman of the department can ignite the latent spark, but in other instances it may prove to be "dragging the horse to water but not making him drink." Only after we, as educators, are convinced that we have tried to imbue the medical student with a proper *modus operandi* based on the concepts previously described can we feel that we have done all in our power to train him for the important task that lies ahead of him.

These are some of the concrete suggestions that I think might improve the present status of medicine. The implication is that the chairman of each department at the medical school must really understand that his *raison d'être* is to discharge his duties assiduously and enthusiastically in the direction of educating future doctors. He should inculcate in members of his staff not only his over-all philosophy, but also specific ideas of what the medical student should be taught. He should then oversee the entire program to make sure that it does not become stagnant or obsolete. Staff meetings should be held at least several times a year for the express purpose of discussing ways of improving student teaching. I realize that every department head has many other obligations, but his primary concern

should center about the training and education of future doctors. What could be a more sacred trust? In this connection, Lippard stated: "When I see the man who has been successful in the competition for academic prestige, the department chairman, so overwhelmed with problems of hospital service and organization, consultation, practice and fund-raising that he is going around in circles and has little or no time to be a scholar, I wonder that we are so well off. I also wonder whether the medical school is not becoming the haven for the man who would avoid the rigorous competition of independent practice yet wishes to continue to operate in a narrow technical field, rather than the man of broad background and wide interest who has the capacity to kindle in his students the desire to join in an exciting life venture."<sup>2</sup>

The art of medicine cannot be measured by the number of medical facts acquired, but by more subtle considerations which include a proper physician-patient relationship, an insatiable thirst for knowledge, the ability to reason logically and above all, the faculty to think clearly. Sound logic is often lost in a maze of disjointed minutiae. The student should be encouraged to be extremely self-critical and to avoid the psychological mechanisms of rationalization and projection. Peabody once said, "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."<sup>3</sup>

<sup>1</sup> Lippard, V. W. "The Medical School—Janus of the University," *J. Med. Education*, 1955, 30:698-706.

<sup>2</sup> Lippard, V. W. *op. cit.*

<sup>3</sup> Peabody, F. W. *Care of the Patient*. Cambridge: Harvard University Press, 1927.



# Editorial

## DESTINY THAT SHAPES OUR ENDS

There is an insidious yet honorable force that directs the students' destiny in medicine. For some entering medical schools today, ultimate accomplishments will be the logical result of their own decisions. But for the majority the course to be followed will be determined to an appreciable extent by the medical school itself, its teachers and its philosophy.

Students generally enter Harvard Medical School with open altruistic minds. They take a justifiable pride in being part of an exceptional group, and they are given to understand that the Hippocratic Oath is to be their credo and *the care of the patient* their objective. And so it is, but not in so clear a form as Hippocrates has stated.

Harvard's Medical School—and most of the others—instills into its students the desire to contribute to the care of the patient not only directly in the sick-room, but more especially in the reputable ways of research. The unsophisticated objective of graduating from medical school, developing for a year or two in postgraduate training, and then settling into a small town simply to devote one's life to the care of the patient is almost heresy. And why? The reasons are not hard to find.

Any top-flight medical school today imbues in its students the investigative spirit. The inquiring mind is solicited and the untiring mind finds a channel for its cerebrational activity. And as a result, the outstanding student usually becomes well-nigh intoxicated with a desire to contribute to the renaissance of learning that is continuously going on around him. No one can quarrel with the importance of this stimulus. Without the inquiring mind and the sometimes feverish activity of its possessor the advances in medicine and surgery that are the hallmark of the "best" medical schools would not be forthcoming. Such advances would not then be translatable into patient care, which, as Dr. Alfred Hurwitz reminds us elsewhere in this issue of the *Bulletin*, is the original objective.

If, as Hurwitz suggests, we have strayed away like lost sheep from the "bedside" form of intimate patient care in our ways of teaching, his statement must nonetheless be interpreted in the light of modern medicine. Bedside teaching (the care of the patient) is still the most vital part of the curriculum. Its relative importance has indeed shrunk as medicine and surgery have become more complicated and as knowledge of disease has become somewhat more complete and certainly more complex. There is so much more to be taught and yet no more hours in which to teach. Moreover, a school that is richly endowed with library, bibliographies, test tubes and tracers would experience an internal upheaval of no mean proportions if the attempt were made to suppress emphasis on investigation. This emphasis is the "insidious, yet honorable force" which will mold to an appreciable extent the embryo student whether we like it or no—and most of us like it.

No, the emphasis on investigative endeavor is not to be curbed, and should be an integral part of the conscience of the doctor planning to "practice" medicine. But equally vital, "the care of the patient" is perhaps the most precious part of a goal that should never be lost to sight by the "scientist" who gets heady glimpses of his own discoveries.



# The Birth of Sherlock Holmes

*Robert M. Goldwyn, '56*

Editor's note: The following paper by a member of the Class of 1956 was presented as the subject of his Boylston Medical Society dissertation in March 1956. It is apparent that the tastes and interests of the undergraduate are not limited to purely clinical studies, which in this day of emphasis upon the "whole patient" would seem to be important.

To avoid any misconception that might literally arise from the title, I will now state that this is not an obstetrical treatise, but a brief account of the origins of the Sherlock Holmes stories and the early life of the medical man who wrote them.

In Edinburgh in 1859, Arthur Conan Doyle was born into what he called "the hardy and bracing atmosphere of poverty." An impractical provider for his wife and seven children, Doyle's father supplemented

his meager government clerk's salary by occasionally selling one of his water color paintings. Doyle's early education was in a public school, and then he entered a Jesuit prep school. The DoYLES were Catholic and Arthur's later agnosticism was a marked contrast to his early orientation. He finished preparatory work at 17, and because he was considered too young to enter professional training at a university, he was sent to a Jesuit school in Germany. He returned in a year and had to choose a career. Doyle says simply, "It had been determined that I should be a doctor chiefly, I think, because Edinburgh was so famous a center for medical learning." "I entered as a student in October 1876 and I emerged as a Bachelor of Medicine in August 1881—between these two points lies one long weary grind at botany, chemistry, anatomy—and a

whole list of compulsory subjects, many of which have a very indirect bearing upon the art of curing."

At Edinburgh, Doyle met someone who influenced his entire life. That person was Joseph Bell, a surgeon at the Edinburgh Infirmary. The Bells were the Edinburgh counterpart of the Boston Warrens. From 1771, for 140 consecutive years, there was on the Roll of Fellows of the Royal College of Surgeons either a Benjamin or Joseph Bell. The Joseph Bell of Doyle's era had been graduated from Edinburgh in 1859, the year of Doyle's birth. Doyle describes Bell: "He was then wiry, dark, with a high-nosed, acute face, penetrating gray eyes, angular shoulders." Bell would tell his students, "Try to learn the features of a disease or injury precisely as you know the features of the gait and tricks of mannerism of your most intimate friend. There



is nothing so important as trifles." Bell was an excellent surgeon, but in Doyle's words, "his strong point was diagnosis not only of disease, but of occupation and character."

Bell appointed Doyle his OPD clerk, and *A Study in Scarlet* contains an incident which Doyle took directly from those days. Bell said to a civilian patient, "Well, my man, you've served in the Army."

"Aye sir."

"Not long discharged?"

"No sir."

"A Highland regiment?"

"Aye sir."

"A non-com officer?"

"Aye sir."

"Stationed at Barbados?"

"Aye sir."

"You see, gentlemen," Bell explained, "the man is a respectful man, yet did not remove his hat. They do not in the Army, but he would have learned civilian ways had he been long discharged. He has an air of authority and he is obviously Scottish. As to Barbados, his complaint is elephantiasis, which is West Indian and not British." Like Holmes, Bell could tell the part of the city from which a patient came by the mud on his clothes. But when Doyle created Sherlock Holmes, Bell was not flattered to find himself a fictional character, especially one with eccentricities quite foreign to himself, such as untidiness, cocaine addiction and indoor revolver practice. But later, as the fame of Holmes spread, Bell became very much interested and suggested to Doyle certain plots—mostly impractical.

At medical school, Doyle says, "I won no distinction in the race—I was always one of the ruck, neither lingering nor gaining." Actually there were reasons for this. Because of insufficient funds, he arranged to compress a year's work into a half-year, leaving the remaining months to earn money, usually as a physician's assistant. Doyle also was a ship's surgeon on a seven-month Arctic whaling expedition, and after graduation he served in the same capacity on a

four-month West African cruise. Upon return, he went to Plymouth as an associate in a lucrative office of a classmate who was half-quack, half-genius. His association with this paranoid eccentric, Cullingworth, soon ended and Doyle went to Portsmouth to open a dreary miniscule office. His patients were mostly transients and those unable to pay their preferred doctor. At 26, Doyle married Louise Hawkins, who had come to Portsmouth with her widowed mother and a younger brother suffering from cerebral meningitis. Doyle cared for the brother, but he soon died, and a year later Louise and he were married. Doyle was married to her 21 years until her death in 1906. He was then re-married—to Jean Leckie, whom he had met a few years before Louise's death. His first marriage was marred by Louise's invalidism from tuberculosis contracted two years after their marriage.

In his early twenties Doyle wrote a few short adventure stories which "served their purpose in relieving me of that financial burden that always pressed upon me." Doyle felt that he was making no literary progress by writing only short stories. He wanted to assert his individuality in a book; he wanted to do something striking and new. Doyle writes: "Gaboriau had rather attracted me by the neat dovetailing of his plots, and Poe's masterful detective M. Dupin had been from boyhood one of my heroes. But could I bring an addition of my own? I thought of my old teacher Joe Bell, of his eagle face, of his curious ways, and of his eerie trick of spotting details. If he were a detective he would surely reduce the fascinating but unorganized business to something nearer to an exact science. . . It is all very well to say that a man is clever, but the reader wants to see examples of it—such examples Bell gave us every day on the wards. . . What should I call this fellow? First it was Sherringford Holmes—then it was Sherlock Holmes. He could not tell his own exploits, so he must have a commonplace comrade as a foil. . . A drab

quiet name for this unostentatious man—Watson would do, and so I had my puppets and wrote my *Study in Scarlet*." Of special interest to us is the fact that the name Holmes was derived from Harvard's own poet-anatomist Oliver Wendell Holmes, whom Doyle greatly admired. Only a firm specializing in cheap sensational literature would take *A Study in Scarlet*, and when it appeared in 1887, it was not much of a success.

At about the same time a London dermatologist, Malcolm Morris, advised Doyle to find a specialty and open offices in London. Doyle had amused himself by correcting refractions and prescribing glasses in the Portsmouth Eye Hospital. He decided to go to Vienna to learn optometry. Before leaving, he dashed off six short Sherlock Holmes stories to help defray travelling expenses. Doyle returned to London from Vienna in six months—a specialist in optometry. Every day in his office near Harley Street he sat with not a patient to mar his solitude. Doyle was not only an optometrist, but an optimist. "Could better conditions for reflection and work be found . . . so long as I was thoroughly unsuccessful in my professional venture, there was every chance of improvement of my literary prospects."

The Sherlock Holmes stories that Doyle wrote before going to Vienna and those he wrote in his patientless consulting rooms clicked. By December of 1891, Arthur Conan Doyle was world famous. The public avidly clamored for the Holmes stories and Doyle grudgingly ground them out. One of the most amazing facts about Doyle's life is that he considered his Sherlock Holmes stories on a much lower literary plane than the 40 large novels that he wrote on such subjects as the Huguenots, the Napoleonic era, the English Regency and Medieval England. "I believe that if I had never troubled with Holmes, who has tended to obscure my higher work, my position in literature would at the present be a more commanding one." Today the Holmes-hungry public has for-



gotten the bulk of Doyle's writings. In an attempt to free himself from the chain Holmes held around his neck, Doyle killed him off through Professor Moriarty at Reidsbach Falls in Switzerland, which the author and his wife had recently visited. So realistic was Doyle's portrayal of the now-immortal detective that a shocked, furious, tearful public obliged him to resurrect Holmes, and to reinstate him with Watson at 221 B Baker Street, in the familiar, untidy apartment—with his curved pipe, oriental slippers, smoking jacket, large leather chair, battered violin, and the nearby cocaine, ready for needed stimulation in the trough periods that happen even to the busiest, most successful of London sleuths.

And Watson—who was he? In *Profile by Gaslight*, our own Reginald Fitz delightfully summarizes Dr. Watson's life as seen in the Holmes stories. Arthur Conan Doyle's son writes: "Watson lived, and there is no question in my mind from where my father drew the character. In the early '80's he formed an acquaintanceship in Southsea (England) with a certain Major W. C. Wood, not a medical man. This Major W. was a perfect example of a certain type of Englishman—thick-shouldered and moustached—reasonably intelligent, a good sportsman and so completely lacking in imagination and temperament as to be a perfect foil for my father and for Holmes. Major W. . . . often visited him, and my father took Major W. as his private secretary." He stayed with Doyle until two years before Doyle's death.

I have discussed mainly the early life of Arthur Conan Doyle with emphasis on his medical career and his writing Sherlock Holmes. His later life is very interesting, and for the sake of completeness I should like briefly to mention it.

Doyle participated in the Boer War and in the First World War as a soldier, a medical man and a war correspondent. In the Boer War, he wrote his famous pamphlet defending the British point of view, and

largely for this he was knighted. He later wrote an excellent five-volume history of the Boer War. Before the beginning of World War I, he was one of the first to call attention to the obsolescence of cavalry and to the danger of the German submarines. He was the first to advocate inflatable life belts for ship personnel and metal helmets for infantrymen. Twice he was a candidate for Parliament—unsuccessfully however. Throughout his life, Doyle was an enthusiastic sportsman. He excelled in riding, boxing, cricket, rugby, billiards and motor car racing. He organized the British Olympic squad of 1908. He introduced tourist skiing into Switzerland and also rifle clubs with miniature ranges into Great Britain. He tried his hand in business, somewhat unsuccessfully in manufacturing iron products, but quite successfully in the production of such varied items as band instruments and post cards. He was the author of four very successful plays. Throughout his life, Doyle showed unbelievable, inexhaustible energy, strength and creativity in many fields.

But the element in Sir Arthur Conan Doyle's life that grew to be the most powerful, the most driving, was his psychic quest—his interest in spiritualism. This began when he was 27 and received its fullest impetus after his oldest son died in the Boer War. In later years, Doyle devoted most of his efforts to propagating spiritualism. He wrote five or six massive books on the subject; he lectured in Europe and America; he contributed large amounts of money to encourage psychic experimentation, and he was encouraging a scientific approach to what he knew others considered to be a fraudulent business. When offered a peerage with the condition that he quietly withdraw from spiritualism, he indignantly refused. Some of his friends, who did not understand the meaning that spiritualism held for him, were amazed that he would pay to have his books on psychic experimentation published when, for the

same effort, he could have received two dollars a word for a Holmes story. He was always ready to offer brave, vigorous assistance to those who needed it. Christopher Morley rightfully named him "the infancaninophile—the helper of the underdog." When Sir Arthur Conan Doyle died in 1930, his wife had inscribed on his headstone of British oak four words that captured for her and recall to us something of the essence of this remarkable man: "Steel True, Blade Straight."

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#### DIAGNOSIS DEFERRED

On the next page of the *Bulletin* will be found a new, as-yet-unnamed column, or page, or department—call it what you will. The Editors in a terminal agony of indecision temporarily earmarked it "Diagnosis Deferred" and put it out of mind by sending it to the printer. Some may think of it as the "Stethoscope" warmed over—"hotted up" as they say in Britain. The important point is that many things are most wisely left unsettled. And after all, "what's in a name?" This issue's column deals with Edward Augustus Holyoke and is entitled, "The Last Leaf."



# The Last Leaf

Edward Augustus Holyoke, M.D., 1783 (Hon.)



The miniature that is being conned with such interest by Drs. Lanman, Churchill and Yakovlev, now reposes in the Warren Museum. A likeness of Harvard's most famous medical centenarian, Edward Augustus Holyoke, of Salem, the portrait was painted on the thirty-eighth day of the doctor's ninety-ninth year. He lived thereafter, as Burrage delicately phrases it in his *History of the Massachusetts Medical Society*, "to the great age of one hundred years and eight months, lacking one day." The accompanying silhouette was published in the *Boston Medical and Surgical Journal* in 1881, on the occasion of the Society's Centennial observance.

This record survival may (or may not) be attributed to the fact that

Dr. Holyoke was a methodical and industrious person who always found occupation for his leisure moments; or because, on realizing that his patients were accustomed to call him after he had retired at night he had acquired the habit of outstaying these summonses and rising correspondingly late in the morning (7:00 a.m.). Had present traffic conditions obtained, his record of never having traveled more than 50 miles from Salem in his professional life of eighty years might easily have accounted for his longevity.

The Holyoke family of Massachusetts Bay sprang from one Edward Holiock, known to have been a Freeman in Lynn in 1638. A later Edward, the father of Edward Augustus, graduated from Harvard in

1705, entered the ministry and served a parish at Marblehead, from which he was called to the presidency of the College in 1737. He survived this academic ordeal for thirty-two years, presiding over the institution's onward destinies until his death in 1769. Edward Augustus's mother, Margaret Appleton, of Ipswich, was descended from John Rogers, the Smithfield martyr, a plaque to whose memory, and that of others, may be found on the wall of St. Bartholomew's Hospital. It is of passing interest that a more recent ancestor, John Rogers, an Ipswich preacher and practitioner of physic was briefly Harvard's president from 1683 until his death on Commencement day in the following year.

Edward Augustus Holyoke was born in Marblehead in 1728, graduated from Harvard College in 1746 and studied medicine as an apprentice to Dr. Berry of Ipswich. As a general practitioner in Salem he became the foremost physician in New England, the preceptor of John Warren, James Jackson and others. Lacking the antibiotics, the corticosteroids and the ataractics he based his singularly successful practice on mercury, antimony, opium and quinine, charged 11 cents for a house call and never witnessed the amputation of a limb.

Holyoke was one of the original incorporators of the American Academy of Arts and Sciences in 1780 as well as of the Massachusetts Medical Society a year later. Since 8 of the 31 incorporators of the Society had also been incorporators of



the Academy, and the charters of the two are in places identically worded, the founding of the Academy may perhaps be considered as a rehearsal for the medical event.

Having served as the first president of the Society from 1781 to 1784 Holyoke became also its third in 1786, the only presiding officer elected to two nonconsecutive terms. In 1783, the year after the Medical School was founded, he was awarded the first honorary degree of Doctor of Medicine from Harvard; in 1813 he received an L.L.D. *honoris causa*.

According to Burrage, Dr. Holyoke was "a constant observer of the external rites of Christianity, and habitually gave much time to theological inquiries, especially during the last forty years of his life." Had Holyoke been better acquainted with Oliver Wendell Holmes, who unfortunately happened not to have been born until the doctor was eighty-one years old, he would probably have seconded the poet-physician's well-known sentiments:

And if I should live to be  
The last leaf upon the tree  
In the spring,  
Let them smile, as I do now,  
At the old forsaken bough  
Where I cling.

## BOOK REVIEWS

HINSHAW, H. CORWIN and GARLAND, L. HENRY: *Diseases of the Chest*. W. B. Saunders Company, 1956. 686 pages.

Several useful texts in recent years have partially satisfied the need for an up-to-date presentation of the recently much expanded field of pulmonary diseases. None has performed the function more satisfactorily than the recently published work of Hinshaw and Garland which achieves the happy coordination of the points of view of an internist who has specialized in chest diseases and that of a radiologist. The primary importance of roentgen interpretation in the diagnosis of pulmonary diseases is accorded proper recognition in the wealth of fine illustrations of characteristic roentgenograms.

The book deals exclusively with pulmonary diseases and does not attempt to cover cardiovascular problems. Following the first introductory chapters dealing with diagnostic procedures including bronchoscopy, laboratory studies and roentgen examination, there are two lucid chapters on segmental anatomy and modern pulmonary physiology. Each disease or group of diseases are dealt with in a consistent fashion considering in turn etiology, pathology, clinical manifestations, laboratory findings, roentgenology, differential diagnosis, treatment, complications, prognosis and prevention. The seven chapters on pulmonary tuberculosis are about as complete and up-to-date a review of the subject as can be found. In all sections the evaluation of the relative roles of medical and surgical treatment is consistently on target.

In addition to their lucid writing and beautiful organization of the material, the authors have avoided the pitfall of pedantry which limits the usefulness of many reference texts for the practicing physician. They are to be congratulated on their common sense approach and the emphasis of the practical rather than the erudite. Many common misconceptions about pulmonary diseases are put straight in a clear, logical fashion and proper editorial emphasis is given to what is important. Their statement concerning bronchitis is characteristic—"To the layman, bronchitis is synonymous with cough and thus includes a host of diseases. To the physician, chronic bronchitis is a diagnosis to be shunned and determined only after exclusion of parenchymal pulmonary disease."

It would be surprising indeed if the reviewer did not hold some opinions that differed from those of the authors, but these are an unimportant minority. In general, I believe that this book provides a valuable and timely reference for every practicing physician and a worthy text for every medical student.

HARRISON BLACK, '43B

SADOVE, MAX S. and CROSS, JAMES H.: *The Recovery Room, Immediate Postoperative Management*. W. B. Saunders Company, Philadelphia, 1956. 597 pages.

This volume with an introduction by Warren H. Cole, Professor of Surgery at the University of Illinois, has been written by physicians in the surgical specialties at the several medical schools in Chicago. The first chapter discusses an administrator's viewpoint of intensive therapy, the second chapter, principles of recovery room management and the third, "management of the circulation, shock, respiration and nutrition." Except for a final section on nursing care and one on management of medical problems, the remainder of this book comprising 16 other chapters is devoted to pre- and postoperative care in special fields of surgery. Essentially then, the caption given this work is a misnomer. On the other hand, since postoperative care is frequently given in a recovery room, the designation may be condoned.

The authors' concept of a recovery room is broad. They speak more of an intensive therapy unit where any patient requiring specialized observation and treatment may be temporarily or permanently housed. Thus the postoperative patient, the seriously ill cardiac, the poisoned, the cerebrovascular accident, and the comatose might all be cared for in the same area. The arguments for and against this plan are not presented clearly nor supported by sufficient data.

Too many topics are discussed in this book. As a result, subjects of real importance to the immediate postoperative period have been abbreviated and inaccuracies introduced. Should nutrition have been included, and can this matter be presented adequately in two and a half pages? A similar space is allocated to therapy in water and electrolyte deficit. Pain is reviewed in two pages. In connection with its treatment, mention is made that 30 milligrams of morphine should rarely be used; but with this quantity of morphine the sensorium is dulled and the patient is less aware of pain. This seems like an unnecessary recommendation and an understatement at the same time.

For whom was this book written? It will be of assistance to those seeking to establish a recovery room. Nurses in the recovery area will find it a useful reference work. Very likely physicians will find it inadequate in theory and will prefer their own concepts of pre- and postoperative care. The volume is a handy size and nicely printed.

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# RETIREMENTS

The retirements of four members of the Medical School Faculty were announced during the late spring and early summer.

Joseph C. Aub, '14, formerly Professor of Research Medicine, Chairman of the Department of Medicine and Director of the School's laboratories in the Collis P. Huntington Memorial Hospital, has now become Professor of Research Medicine, *Emeritus*.

Born in Cincinnati, Ohio, May 13, 1890, Dr. Aub received his A.B. from Harvard College in 1911. After graduating from the Medical School in 1914, he completed his internship and residency at Massachusetts General Hospital, and then joined the Medical School staff in 1916 as a Teaching Fellow in Medicine. He served in France during World War I and returned to Harvard as Assistant Professor of Physiology. His early research (1917-1925) contributed to the discovery of the importance of calcium metabolism in lead poisoning. In 1928 Dr. Aub was appointed Physician-in-Chief at the Collis P. Huntington Memorial Hospital and a member of the Cancer Commission of Harvard University. As a member of the latter organization, he directed research into the roles played by glands of internal secretion, among them the adrenals, thyroid, parathyroid and pituitary, in the control of cell growth.

In 1942 Dr. Aub was appointed physician at the Massachusetts General Hospital and Professor of Research Medicine at the Medical School. He was named Director of the Medical Laboratories at the Huntington Hospital in 1943.

The author of more than 150 scientific publications, Dr. Aub has served as an advisor to many organizations and foundations, including the Atomic Energy Commission Project at the University of California, the National

Research Council and the National Advisory Cancer Council. In 1953 he visited India as a member of a group of scientists seeking to exchange medical information with Indian physicians, medical educators and public health specialists under the auspices of the World Health Organization and the Unitarian Service Committee. In recognition of his services under sponsorship of the latter organization in Czechoslovakia he was decorated with the Order of the White Lion. Earlier this year in Houston, Texas, Dr. Aub was presented with the 1956 Bertner Foundation Award for outstanding contributions in the field of cancer research. This year he was elected to an honorary membership in the graduating class at Harvard Medical School.

\* \* \*

Dr. Merrill Clary Sosman, Professor of Radiology at the Peter Bent Brigham Hospital and Chairman of the Department of Radiology at the Medical School, retired this past summer. His new title is Professor *Emeritus* of Radiology.

Born at Chillicothe, Ohio, June 23, 1890, Dr. Sosman received the A.B. degree from the University of Wisconsin in 1913 and the M.D. from the Johns Hopkins Medical School in 1917. Prior to joining the Harvard Medical School staff as an Assistant in Roentgenology in 1922, Dr. Sosman was a roentgenologist on the staff of Walter Reed General Hospital, Washington. He became Professor of Roentgenology at the Peter Bent Brigham Hospital in 1949.

Dr. Sosman is an authority on the use of the roentgen ray as an important diagnostic and therapeutic tool. He widened considerably the scope of radiology and lent the weight of his remarkable knowledge of medicine and surgery to the clinical interpretation of the X-ray film.

Dr. Samuel A. Levine, Clinical Professor of Medicine at Harvard, in a recent ceremony involving the unveiling of a portrait of Dr. Sosman at Peter Bent Brigham Hospital, characterized him as:

"A great clinical teacher who has set the standard for radiology conferences. . . . His method of teaching has been unique—a mixture of keen erudition and a panoramic knowledge of general medicine, surgery and pathology, combined with his own individual dramatic wit and humor. He considers the patient as a whole and endeavors to teach him as a human being."

\* \* \*

John Rock, '18, an authority on the physiology of human reproduction, has retired from the Medical School staff to become Clinical Professor of Gynecology, *Emeritus*.

A native of Marlboro, Massachusetts, Dr. Rock received the S.B. degree from Harvard College in 1915, and has been associated with the Medical School since his appointment as Assistant in Obstetrics in 1922. He became Clinical Professor of Gynecology in 1947. At the Free Hospital for Women in Brookline, he established one of the first Fertility Clinics in this country and served as its Director for nearly 30 years. He is currently Consulting Gynecologist and Director of the Rock Reproductive Study Center at the Free Hospital for Women, and also a Member of the Board of Consultants of the Massachusetts General Hospital.

In collaboration with Dr. Arthur T. Hertig, Professor of Pathological Anatomy in the Medical School, Dr. Rock participated in the collection and description of the early stages in the development of the human ovum. These studies also included observations on abnormal development during gestation.

In 1948, Dr. Rock received the

Lasker Award of the Planned Parenthood Federation of America; and in the following year, the Ortho Award of the American Gynecological Society. He is a member of the Harvard Medical Alumni Council.


\* \* \*

Also retiring is Harry C. Solomon, '14, who now becomes Professor of Psychiatry, *Emeritus*. He will continue as Medical Director and Superintendent of the Boston Psychopathic Hospital, the major center for the teaching of psychiatry in the Medical School.

Dr. Solomon, who was born in Hastings, Nebraska, on October 25, 1889, attended school in Los Angeles before entering the University of California, from which he received the B.S. degree in 1910. He joined the staff of the Medical School in 1914 as an Assistant in Neuropathology, and at the same time was an intern and Junior Assistant at the Boston Psychopathic Hospital. A First Lieutenant with the Army Medical Corps in 1918-19, he also served during World War II as Chief Neuropsychiatric Examiner of the Boston Recruiting and Induction Station and as Special Consultant to the Secretary of War. From 1919 to 1943 Dr. Solomon was Visiting Neurologist at the Massachusetts General Hospital and Visiting Neuropsychiatrist at Beth Israel Hospital.

Recognized internationally as a leader in the field of psychiatry, Dr. Solomon has developed at the Boston Psychopathic Hospital not only the therapy of patients, but research and the education of all those involved in patient care. Here, too, he led in the inauguration of a series of children's clinics in mental health which serve for training, research and treatment. He has served as a consultant on plans for new legal medicine facilities for the service of the courts in Massachusetts, and was recently appointed by Governor Herter to the Advisory Committee to the Massachusetts Department of Correction. Dr. Solomon has devoted considerable study to the ever-increasing role of psychiatry in the social sciences.

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## "GET THE OTHER LAMP, SON"

Thomas W. Adams and William H. Cox, '57

"Those two new doctors from the States were down to see old Mrs. Pelley last night. They fixed her up all right, but not until one of them went back to the hospital and asked Dr. Olds what to do!" There are no secrets on Twillingate Island, Newfoundland. Everyone knew when this year's (student) doctors arrived by boat from Lewisporte, and no one was particularly eager to be treated by either of us at first. "Would prefer Dr. Taylor" was post-scripted to many of the first house-call notices we received. Then Mrs. Pelley on the North Side developed congestive failure late one night and we both went to see her and administered digoxin and aminophylline. She recovered rapidly afterwards, but there had been no sterile syringe in the bag and Bill had to run back to the hospital to get one. Hence rumor had it all over town that although Mrs. Pelley pulled through, the student doctors had had to consult with Dr. Olds first! Nevertheless, it was a successful start on Twillingate.

Immediately after our arrival, we were shown the hospital, introduced to the staff, fed, given our quarters and placed "on call." This constituted being on duty every other night and every other weekend; and included all the functions of an intern at one of our general hospitals. Strokes, deliveries and febrile children were among the most common complaints. Calls to houses on Twillingate could take 10 to 30 minutes, while calls to the neighboring islands could take one to two hours via boat. Besides serving as the major means of transportation around Twillingate, these little open dories occasionally serve as delivery rooms, as Bill learned early one morning. He was summoned to the emergency ward by an excited nurse and almost carried, bag and all, down to the wharf by a frenzied father who "thought" his wife had had a baby in a boat while racing for the hospital from a nearby island. Upon reaching the wharf, Bill found the young mother lying in the bow of the boat, her feet supported on the forward seat in good lithotomy position, and her nylon under garments cradling a bloody, screaming newborn girl. Having babies in unusual places is nothing new to Twillingaters. One multipara delivered twins, both breech presentations, on the stretcher on her way to the delivery room; and on our second night there we gave some slight medical aid to a lady who had her baby at home in bed by the light of *two* kerosene lamps! ("Get the other lamp, son; the doctors need lots of light," said the



grandmother as we arrived!) Despite a well-equipped operating and delivery suite, many Twillingate mothers cling to the time-honored and inexpensive method of "having 'em where they fall."

For the past eight summers, H.M.S. IV's have been going to Twillingate in twos and threes in the summer to put into practice some of their knowledge gained in the first three years. There they do essentially all the normal obstetrics, minor surgery, house calls, crude psychotherapy and occasional exodontia. They also assist Dr. J. M. Olds, the chief, at all major surgery, and give routine care to hospitalized and O.P.D. patients. They serve as part-time pharmacists, pathologists, laboratory technicians, bacteriologists, and radiologists. In this manner this past summer we traced down the source and causative organism in an outbreak of typhoid fever, complete with rose spots, palpable spleens and relative bradycardia.

It was a busy summer, medically speaking, but by the end of our stay we felt considerably more competent and confident. More important, our almost cool reception slowly grew into a warm acceptance by the townspeople as friends and as doctors. For example, as he was leaving an old fisherman's house, Tom was amused but pleased to hear the old gentleman say, "By the way, Doc, be sure to tell me your name, so that I can ask for you by name when I come to the hospital for those X-rays. I hear they have a bunch of *students* there, and I sure wouldn't want to be seen by one of them!" That statement characterized our wonderful summer on Twillingate.

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# Busman's Holiday

"This is a great medical school . . . great things are going on." ". . . a very rewarding experience." ". . . the most interesting course I have ever taken." "I was impressed with the unassuming nature that all the teaching personnel exhibited. Here were men, great in their field, yet just as human and friendly as any of us and more so." "I take back all the unkind things I used to say about Harvard."

These were some of the comments expressed by 19 high school science teachers from all parts of the country after they completed an eight-week course at the Medical School this past summer. The course, "Principles of Radioactive Measurement," was aimed at improving the caliber of high school science teachers and spurring the interest of students in science careers.

The program, under the joint sponsorship of the Atomic Energy Commission and the National Science Foundation, in collaboration with the Harvard Summer School and Graduate School of Education, drew teachers from the larger high schools in 10 states, who were nominated by the schools and selected by the Harvard Faculty. The course was offered through the Medical School's Biophysical Laboratory under the direction of Dr. Arthur K. Solomon and was admittedly a trial balloon for both the A.E.C. and the N.S.F. For Harvard it was a doubly new experience, for the Medical School had never before offered summer courses to non-medical students. In undertaking this experiment, the sponsors were seeking to determine whether or not 1)

the high school science teachers would benefit by such training, 2) they would be sufficiently "fired" to transfer their enthusiasm to their students, and 3) they could pass on—in chain reaction fashion—their new knowledge to other high school science teachers in their home communities.

In explaining the program, Fletcher Watson, Associate Professor of Education at Harvard, said, "The scientific and technological developments of the future will grow from the developments of the present." Noting that "Nuclear power and the uses of radioisotopes in industry, biology and medicine are certain to be increasingly important in the future," Professor Watson continued, "The adults who will carry out these developments and live in this changing environment are the children who come through our schools. To point them toward their future, the school curriculum must include an introduction to the present efforts that will become increasingly significant."

The teacher-students were warned at the outset that the course would be difficult. It brought into use the basic ingredients of science teaching—mathematics, chemistry and physics—and the students soon found the pressure applied in daily lectures, weekly problem sessions and laboratory experiments devoted to the techniques of radioactive measurements in modern biology. One student said, "I never worked so hard in my life." Criticisms were in general mild, and confined primarily to the amount of material covered and the short space of time involved.



*Albert M. Goldfarb of Philadelphia, Edwin H. Cooper of Madison, New Jersey and Robert A. Chemas of Pittsburgh use an electronic scaler to measure the strength of the radioactivity in a chemical sample.*

Materially, as well as intellectually, each of the teachers carried something away from the School on their departure in late August. As an aid to classroom instruction they received kits containing instruments for detecting and measuring radioactivity and simple apparatus for conducting classroom experiments. These were donated without cost by the Atomic Energy Commission, who also offered the course free of charge to the students.

In summing up the course, Professor Solomon said, "Our goal was to provide the best possible educational program for the eight weeks available. We wanted the group of teachers to feel that science is exciting and that new ideas are invigorating. In this, I am confident we were successful. We're planning ahead for next year with increased enthusiasm."



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# HONORS



At the one hundred and thirty-second Commencement of the Jefferson Medical College, June 15, 1956, the Board of Trustees presented Joseph C. Aub with the honorary degree of Doctor of Science. Dr. Aub, who graduated from Harvard Medical School in 1914, was described as "an outstanding figure in American medicine." The Jefferson citation continued, "Dr. Aub has blended human warmth with the quest for scientific truth. His research interests have ranged over wide areas of medicine, bringing contributions to our understanding of shock, industrial toxicology, and cancer. Over many years he has maintained the eager, open mind of the good investigator. His students are many and devoted. Dr. Aub combines the best qualities of scientist, teacher, physician and friend." (For other news of Dr. Aub, see page 26.)

\* \* \*

Among recipients of honorary degrees at the Dartmouth College Commencement exercises, June 10,

1956, was Hildrus Augustus Poindexter, '29, who was awarded the degree of Doctor of Science, *honoris causa*. The citation read by President Dickey: "Hildrus Augustus Poindexter: Lincoln University A.B., graduate of the Dartmouth Medical School in 1927, Harvard M.D., Columbia A.M. and Ph.D., sometime fellow of the Rockefeller Foundation, Professor of Howard University, Colonel of the United States Army Medical Corps and onetime porter of the Pullman Company, you have the rare distinction of having saved human lives on a vast scale. Born into the poverty of a farming family in Shelby County, Tennessee, educated through the generosity of others and your own determination, you equipped yourself to become a world authority on the control and elimination of malaria, the largest health impairment of human effort on the face of the earth. As teacher and researcher and author of some seventy scientific publications in microbiology and public health, as army officer, administrator and public health official you have followed the trail of the malaria-bearing

mosquito into well nigh all the continents and archipelagos of the world. Holder of the Bronze Star for spectacular reduction of the malaria scourge among our soldiers in the South Pacific, Knight Commander of Liberia for a similar service to that land, Dartmouth where you received your first professional education, is proud to count you among the most honored in her fellowship. . . ."

Dr. Poindexter, has spent most of his time since World War II abroad, in the Pacific and Japan at the end of the war and during the early days of the occupation, then six years in Africa, and most recently in Saigon, Indochina. Between these assignments he has spent some time in the Caribbean, South and Central America, Europe and the Near East. While in Africa he served as Director of the Public Health Service Mission in Liberia, medical attaché to the American Embassy at Monrovia (Liberia) and public health advisor to the Bureau of Public Health and Sanitation in Liberia. In March of 1955 he became Chief of the Division of Health and Sanitation with the FOA/Saigon, Indochina Mission.



Miss Olney with the Governor

Many users of the Medical School Library are acquainted with Miss Helen Olney, a member of the staff for the past 21 years. Something they may not be aware of is that she is the great grand niece of Clara Barton, founder of the Red Cross.

On June 1, 1956, at the State House in Boston, Miss Olney was presented with a proclamation signed by Governor Christian Herter, of Massachusetts, commemorating the 75th anniversary of the Red Cross. Early in October she was guest of honor at the celebration of Founder's Day in Rochester, New York, the principle event of which

was a motor cavalcade from Dansville, New York, home of the oldest Red Cross chapter in the United States—to Rochester, where the second chapter was founded a few weeks later.

Miss Olney is a native of Oxford, Massachusetts, who received her A.B. from Wheaton College. Before coming to the Medical School in August 1935, she worked for the Bibliographical Society of America. A former teacher of French and Modern European History in New York State, Miss Olney continues her studies in her free time during the winter.





